EATING DISORDER TREATMENT

HS-297

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND

WellCare adheres to the guidance of the American Psychiatric Association (APA) in determining the treatment needs of members with eating disorders (ED). WellCare believes the following statements to be appropriate guidelines for treatment decisions and system of care interventions of ED:

- The treatment of ED is complex and requires an integrated approach to balance and manage all the co-morbid psychiatric and medical conditions present when these members access care.
• The psychogenic dynamics that contribute to the development of eating disorders require attention or the condition is extremely likely to continue and to escalate.
• Treating the whole person within their living environment is crucial to treatment success.
• The absence of specialty practitioners or a full spectrum of care in each community to treat these specialty conditions is a system of care deficit that needs to be considered and addressed as much as possible to facilitate best practices in the treatment of ED.
• Integrated Care Programs are the best paradigm to treat ED conditions.

In August 2012, the APA issued a practice guideline ‘watch’ for ED. In it they published their findings about treatment outcomes and treatment settings. The following was outlined:

- Full recovery rates on members with ED are poor, at only 33% after 2 years in the study group;
- Treatment adherence was lowest with the inpatient treatment group, at only 50% as compared with 71% for the outpatient group and 77% for the specialist outpatient group;
- First line inpatient treatment does not provide advantages over outpatient treatment;
- Patients who do not respond to outpatient treatment do poorly on transfer to inpatient facilities;
- Specialist outpatient treatment was found to be the most effective/cost-effective treatment and had the highest patient satisfaction rates; AND
- There is little support for long-term inpatient (residential) care.

The potential for co-morbid conditions is high and can include mental health disorders, substance use disorders and medical conditions. ED cases are medically complex and can represent high acuity clinical situations. The potential for co-morbid behavior is high. Psychosis can be present in the clinical picture of a member with ED- most often related to PTSD and/or major depression. Depression and Anxiety are frequent co-morbid behavioral health conditions. Additionally there is a high prevalence of borderline personality disorder. As needed psychotropic drugs can be a valuable treatment adjunct. Considerations include the potential effect and side effects. Some drugs may help with weight gain in addition to controlling psychotic symptoms. Careful dosing is necessary with members whose weight or other medical conditions provide potential drug interactions or the potential for serious side effects.

The development of eating disorders is almost always connected to negative family dynamics - most notably the mother/daughter relationship. Initially, achieving a sense of power and control is the primary conscious or unconscious gain that motivates the member to take unhealthy charge of their eating. Whether the problem is bulimia or anorexia, unless the psychogenic issues are resolved the symptoms usually escalate. Family involvement and therapy is a crucial factor that determines the potential for successful treatment.

Psychoeducational interventions with the member and the family related to the individual/family dynamics, the nature of the ED, and the individual’s emotional issues are considered to be helpful. Additionally, nutritional counseling is vital to assist the member with assuming healthy control of their intake.

Indications for Referral

1. Member safety is always the first priority. If the member is at risk of physical bodily harm due to the medical complications of ED and meets inpatient criteria, WellCare will manage medical inpatient services to stabilize the member’s acute physical condition and facilitate an appropriate discharge. Likewise, if the behavioral health symptoms are the most acute and the member meets inpatient criteria, WellCare will manage psychiatric inpatient services to stabilize the member’s psychiatric condition and facilitate an appropriate discharge.
2. The goal of any inpatient admission is rapid stabilization and engagement with specialized outpatient services.
3. WellCare will consider the use of specialized psychiatric outpatient treatment that includes nutritional support and needed medical services the best practice for the treatment of ED.
4. As indicated for each member based on criteria and the APA guidelines, intensive outpatient or partial hospitalization services may be an appropriate treatment response to those who need more intensive treatment than available in specialized outpatient treatment.
5. There is no evidence to support the use of long-term inpatient services in any setting (residential, crisis stabilization units, or acute inpatient facilities) and removing children from their families unless there is clear and convincing evidence of abuse or neglect is contraindicated.
6. WellCare will automatically assign a case manager to work with the integrated medical/psychiatric Utilization Management staff on treatment alternatives and discharge planning to promote the best possible outcomes.

POSITION STATEMENT

Applicable To:
- Medicaid
- Medicare

Immediate Safety Risk

For members with an immediate safety risk, treatment of eating disorders is considered medically necessary and a covered benefit when one of the following are met:

1. Suicide / Homicide attempt within the last 48 hours; OR

2. Suicidal / Homicidal ideation with at least one of the following:
   - Specific plan
   - Non-specific plan with means and no deterrents
   - Attempt within the last two months with high lethality or intent OR refusal to disclose current plan;
   - Refusal to disclose current plan with access to firearms or other lethal means OR is impulsive or agitated
   - Anxiety and substance use within the last 24 hours

OR,

3. Non-suicidal self-injury within the last six hours with increased frequency / intensity AND professional medical attention required; OR

4. Body dysmorphic with delusions and food refusal; OR

5. Weight < 75% (0.75) average body weight (ABW) / BMI < 16; OR

6. Weight loss ≥ 15%(0.15) within last month; OR

7. Unstable medical sequelae of eating disorder with one of the following:
   - Cardiac arrhythmia
   - Ipecac-induced cardiomyopathy
   - Sodium > 150 mEq/L(150 mmol/L)
   - Sodium < 130 mEq/L(130 mmol/L)
   - Potassium < 3.0 mEq/L(3.0 mmol/L)
   - Magnesium < 1.4 mEq/L(0.58 mmol/L)
   - Tonic-clonic seizures / Status epilepticus
   - Blood glucose < 60 mg/dL
   - Dehydration
   - Acute refeeding complication
   - Inadequate nutritional intake and dizziness / weakness with at least one of the following:
     - T < 97°F(36.1°C) PO
     - Heart rate > 110/min
     - Heart rate < 40/min
     - Orthostatic changes in heart rate ≥ 20/min
     - BP < 80/50
     - Postural systolic BP drop > 20 / diastolic drop > 10
   - Change in mental status / Mental confusion
   - Comorbid medical condition and unstable lab values requiring daily monitoring
8. History of anorexia at least 5 years with unsuccessful treatment at least two times within the last 2 years and inadequate nutritional intake and subacute medical complications; OR

9. Purging daily (≥ 5 times a day).

Potential Safety Risk Within the Last Week

For members **with a potential safety risk within the last week**, treatment of eating disorders is considered medically necessary and a covered benefit when **one** of the following are met:

1. Suicidal / Homicidal ideation; OR
2. Suspected / Identified eating disorder with at least one of the following:
   - Member must meet at least one of the following **Physiologic Signs and Symptoms:**
     - Weight < 85%(0.85) ABW / BMI 16 to 18 within the last 3 months
     - Orthostatic hypotension
     - Calluses / Abrasions on hands / fingers / knuckles
     - Swollen parotid glands / Poor dentition
     - Esophagitis / GERD / history of gastric rupture
     - Constipation / Abdominal bloating
     - Lanugo / Hair thinning / Alopecia
     - Amenorrhea at least 3 mos / Menstrual irregularities
     - Stress fracture / Osteopenia
     - Cardiac arrhythmia / Mitral valve prolapse
     - Elevated liver function / serum amylase values
     - Comorbid medical condition
   - **OR,**
   - Member must meet at least one of the following **Behavioral / Psychological symptoms:**
     - Self-induced vomiting / Purging behavior
     - Excessive / Compulsive exercising
     - Refusal to eat in the presence of others
     - Calorie restriction / Fasting / Binge eating
     - Ritualistic / Compulsive eating behavior
     - Body image distortion
     - Self-esteem dependent on weight loss
     - Fear of weight gain / obesity
     - History of binge eating and guilt / remorse
   - **OR,**
   - Member must meet at least one of the following **Associated Findings:**
     - Comorbid anxiety / affective disorder
     - Medication / Substance misuse
     - Psychiatric medication nonadherence
     - Non-suicidal self-injury

**LOCUS / CASII Criteria**

For markets that use the Level Of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII), follow the applicable level of care placement.
Level of Care Utilization System (LOCUS) Determination Grid

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Score</th>
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<tbody>
<tr>
<td>Zero</td>
<td>Basic Services for Prevention and Maintenance</td>
<td>7-9</td>
</tr>
<tr>
<td>One</td>
<td>Recovery Maintenance and Health Management</td>
<td>10-13</td>
</tr>
<tr>
<td>Two</td>
<td>Outpatient Services</td>
<td>14-16</td>
</tr>
<tr>
<td>Three</td>
<td>Intensive Outpatient Services</td>
<td>17-19</td>
</tr>
<tr>
<td>Four</td>
<td>Intensive Integrated Services Without 24-Hour Psychiatric Monitoring</td>
<td>20-22</td>
</tr>
<tr>
<td>Five</td>
<td>Non-Secure, 24-Hour Psychiatric Monitoring</td>
<td>23-27</td>
</tr>
<tr>
<td>Six</td>
<td>Secure, 24-Hour Psychiatric Management</td>
<td>28+</td>
</tr>
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</table>

CODING

CPT Codes – No applicable codes.

HCPCS Codes – No applicable codes.

ICD-10-CM Diagnosis Code

F50.00-F50.9  Anorexia nervosa, unspecified (F50.00)

Secondary ICD-10-CM Diagnosis Codes (not all inclusive)

E86.0  Dehydration

G40.301-G40.319  Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus (G40.301)

G40.401-G40.419  Other generalized epilepsy and epileptic syndromes, not intractable, with status epilepticus (G40.401)

I34.1  Nonrheumatic mitral (valve) prolapse
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<tr>
<th>I42.7</th>
<th>Cardiomyopathy due to drug and external agent</th>
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<tr>
<td>I47.0</td>
<td>Paroxysmal tachycardia, unspecified (I47.9)</td>
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<tr>
<td>I47.8</td>
<td>Other specified irregular tachycardia (I47.8)</td>
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<tr>
<td>I48.0</td>
<td>Paroxysmal atrial fibrillation (I48.0)</td>
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<tr>
<td>I48.9</td>
<td>Other specified supraventricular tachycardia (I48.9)</td>
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<tr>
<td>I49.01</td>
<td>Ventricular fibrillation (I49.01)</td>
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<td>I49.9</td>
<td>Other specified ventricular tachycardia (I49.9)</td>
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<td>I50.9</td>
<td>Cardiac arrest (I50.9)</td>
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<tr>
<td>I51.1</td>
<td>Septicemia with endocarditis (I51.1)</td>
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<tr>
<td>I51.8</td>
<td>Other specified endocarditis (I51.8)</td>
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<tr>
<td>K11.8</td>
<td>Secondary pericardial effusion (K11.8)</td>
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<td>Other specified pericarditis (K21.9)</td>
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<td>K59.0</td>
<td>Other specified hypertension (K59.0)</td>
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<td>L64.8</td>
<td>Other congestive heart failure (L64.8)</td>
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<td>N93.0</td>
<td>Nonscarring hair loss, unspecified (N93.0)</td>
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Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply coverage as well as applicable federal and state law.